



IOWA DEPARTMENT OF JUSTICE
Application for Sexual Assault Nurse Examiners and Qualified Providers

Please type or write legibly. Any questions should be directed to the Sexual Assault Response Coordinator at the Iowa Attorney General's Office at 515-281-5044 or SAEProvider@ag.iowa.gov. This form shall be submitted every 3 years with re-approval.

Please check one: [] Initial Application [] Renewal Application

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

License #: _____ License Type (RN, etc.): _____ State: _____ Expiration Date: _____

Preferred Phone: _____ Secondary Phone: _____

Preferred Email: _____ Secondary Email: _____

Date of Adult/Adolescent Sexual Assault Nurse Examiner 40 Hour Training: _____

Training Program: _____ IAFN Approved? [] Yes [] No

Date of Pediatric Sexual Assault Nurse Examiner 40 Hour Training: _____

Training Program: _____ IAFN Approved? [] Yes [] No

Date of MD/DO 30 Hour Training: _____

Training Program: _____

Date of Iowa Specific Training (if course is not Iowa Specific): _____ [] In-Person [] Online

Do you have IAFN Certification: SANE-A: [] Yes [] No SANE-P: [] Yes [] No

Name of SANE Coordinator or Facility Supervisor: _____

Phone: _____ Email: _____

Sexual Assault Nurse Examiner/Qualified Provider Practice:

[] Hospital Based [] Community Based [] CPC/CAC

Approximate number of exams completed in the last 16 months: _____

Are you interested in being a preceptor or mentor? [] Yes [] No

*You must have at least one year experience as a SANE AND completed a minimum of 10 exams.

Required documents to accompany this application:

- [] Copy of Sexual Assault Nurse Examiner or MD/DO Course Certificate
[] Copy of Medical License/Current Verification
[] Signed Qualified Provider Commitment Letter
[] Background Check

If new application, training log to be verified within 6 months of preliminary approval

AG Staff Only:

Date received: _____ Date Approved: _____ Date Denied: _____ Initials: _____ Preceptor: Y/N